Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Corpus Christi Outpatient Surgery 3636 S. Alameda, Ste. A Corpus Christi, TX 78411 Sent	MFDR Tracking #: M4-05-9012-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TML Intergovernmental Risk Pool Rep. Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

OCT 11 2007
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor did not submit a Position Summary; however, the Requestor's rationale on the Table of disputed services states, "requesting interest be allowed to amount in dispute. Letter of appeal submitted with explanation of reimbursement amounts to ASC. Appeal denied paid TX Fee Schedule."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $48.18
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Carrier has paid in accordance with the appropriate ASC Medical Fee Guideline. Requestor is not entitled to additional reimbursement."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute*	Ordered Amount
02/18/05	29880-SG ($597.40 x 213.3%)	1, 2, 3	$34.30	$34.30
02/18/05	29879-SG ($516/20 x 213/3% x 50%)		$13.88	$13.88
Total Due:				$48.18

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.402 titled, *Ambulatory Surgical Center Fee Guideline* effective April 30, 2004, sets out the reimbursement guidelines.

1. The Respondent made reimbursement for the disputed date of service and used payment exception code "W1 – WC state fee schedule adjustment." The Requestor submitted a request for reconsideration and the Respondent used denial codes "13 – Previous Payment for this service already made" and "24 – No additional payment allowed after review."

2. According to Rule 134.402(b) for coding, billing, reporting, and reimbursement of facility services covered in this rule, Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided.

   - The Requestor billed multiple procedures using CPT Codes 29880-SG and 29879-SG. Payment for multiple procedures will be made based on 100 percent of the group rate of the procedure classified in the highest payment group times 213.3% and 50 percent of the group rate for any other covered procedure times 213.3%.

   - CPT Code 29880 is a Group 4 code, Locality 24; therefore the calculation for ASC rates should be as follows: $597.90 x 213.3 = $1,275.32. The Respondent made a payment of $1,241.02; therefore additional reimbursement in the amount of $34.30 is recommended.

   - CPT Code 29879 is a Group 3 code, Locality 24; therefore the calculation for ASC rates should be as follows: $484.01 x 213.3% = $1,132.39 x 50 = $516.20. The Respondent made a payment of $502.32; therefore additional reimbursement in the amount of $13.88 is recommended.

3. Per review of Box 32 on CMS-1500, zip code 78411 is located in Nueces County. The maximum reimbursement amount, under Rule 134.402(b), is determined by Reasonable Charge Locality and group rate.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d) and/or §413.0311
28 Texas Administrative Code Sec. §134.1, §134.402
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $48.18 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Team Lead, Medical Fee Dispute Resolution	October 9, 2007 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P. O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.